MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

Minutes for the June 2016 Meeting

Date: Thursday, June 16th, 2016
1:00 pm – 3:00 pm

Location: Conference Rooms A and B
Capitol Commons Center
400 South Pine
Lansing, Michigan 48909

Commissioners Present:

Patricia Rinvelt, Co-Chair
Karen Parker
Nick Smith
Mark Notman, Ph.D.
Peter Schonfeld
Rozelle Hegeman-Dingle, PharmD
Rodney Davenport, Co-Chair (Phone)
Irita Matthews (Phone)
Robert Milewski (Phone)
Michael Chrissos, M.D (Phone)
Orest Sowirka, D.O. (Phone)
Randall Ritter (Phone)

Commissioners Absent:

Jill Castiglione, RPh

Staff:

Meghan Vanderstelt
Kim Bachelder
Phil Kurdunowicz

Attendees:

Bruce Maki
Chase Bresnahan
Deana M. Newman
Brooke Pearcy
Scott Larsen
Marquilla Chedester
James Bell III
Xiaomeng Du
Ryan Koolen
Rick Wilkening
Cynthia Green-Edwards
Philip Viges
Kristy Brown
Courtney Delgoffe
Laura Houdeshell
Branden Ladner
Lauren Kosowski
Amy Allen
Umbrin Attequi

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, July 16th, 2016 at the Capitol View Building with 12 Commissioners participating in person or by phone.

A. Welcome and Introductions

1. Co-Chair Patricia Rinvelt called the meeting to order at 1:01 p.m.
2. Co-Chair Rinvelt asked the other commissioners to introduce themselves and to share any updates since the last time that the commission convened. The other commissioners did not have any updates to share at this time.
3. Co-Chair Rinvelt noted that the Connecting Michigan Conference was held last week.
    a. Co-Chair Rinvelt noted that the Office of National Coordinator for Health Information Technology (ONC), Michigan Health Information Network (MiHIN), and Healthcare Information and Management Systems Society (HIMSS) orchestrated several workshops to explore opportunities to leverage health information technology to improve the capacity of public health departments to response to disasters.
    b. Co-Chair Rinvelt mentioned that the ONC and HIMSS would be collaborating on developing a white paper on this issue that would be based on the feedback from the Connecting Michigan conference as well as other forums.

B. Commission Business

1. Chair Rinvelt asked the commissioners to review and consider approving the minutes from the January 2016 meeting.
2. Commissioner Peter Schonfeld made a motion to approve the minutes, and Commissioner Rozelle Hegeman-Dingle seconded the motion.
3. Chair Rinvelt asked if there was any objection to approving the minutes. Seeing none, she noted that the minutes had been approved at 1:06 p.m.

C. HIT/HIE Update

1. Co-Chair Rinvelt invited Ms. Meghan Vanderstelt from the Michigan Department of Health and Human Services (MDHHS) to provide an update on new developments in the health information technology (HIT) field since the last commission meeting. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Ms. Vanderstelt noted that the HIT Office had moved from the Capitol View Building to the South Grand Building and that future meetings would be held at the South Grand Building.
3. Ms. Vanderstelt also indicated that the Office of Health Information Technology had been reorganized into the Division of Policy within the Policy, Planning, and Legislative Services Administration. She also remarked that the new Division of Policy would continue to work on health information sharing issues and support the work of the HIT Commission.
4. Ms. Vanderstelt also highlighted different aspects of the HIT Commission Dashboard.
    a. Ms. Vanderstelt mentioned that MiHIN has 61 Trusted Data Sharing Organizations connected to the network.
    b. Ms. Vanderstelt also highlighted how MiHIN was transitioning its legal framework towards the use of a Master Use Case Agreement with smaller Use Case Exhibits, which should reduce the legal review burden for qualified organizations.
    c. Ms. Vanderstelt also drew attention to the shifting of the MDHHS Data Hub into the MDHHS Business Integration Center, which would be described later in the meeting.
    d. Ms. Vanderstelt showcased the work of the Michigan Center for Effective IT Adoption (MCEITA) with the Great Lakes Practice Transformation Network (GLPTN).
        i. Ms. Vanderstelt explained that GLPTN is a multi-state effort that seeks to transform physician practices and help them prepare for payment reform.
        ii. Ms. Vanderstelt noted that the GLTPN had already exceeded the initial enrollment targets for the demonstration.

D. Introduction to the MDHHS Business Integration Center

1. Co-Chair Rinvelt invited Ms. Amy Allen from MDHHS to provide an introduction on the MDHHS Business Integration Center (BIC). The PowerPoint slides for this presentation will be made available on the website after the meeting.
    a. Ms. Allen explained that BIC is primarily focused on coordinating the Department's information technology projects but also assists with coordinating business projects.
    b. Ms. Allen highlighted the three key functions for BIC: strategic alignment, project management, and business integration.
    c. Ms. Allen depicted the role of BIC in supporting the merger of the Department of Community Health and Department of Human Services into the new MDHHS.
        i. Ms. Allen explained that BIC helped with cataloguing all of the different programs and information technology system within the two Departments.
        ii. Ms. Allen noted that the environmental scan results were used by MDHHS to develop the Department's long-term information technology strategy.
    d. Ms. Allen described the challenges of coordinating the various agencies within MDHHS and establishing a global view of all MDHHS programs and information technology systems.
        i. Ms. Allen noted that the Strategic Alignment Team, which is composed of the Department's deputy directors, is instrumental in providing this high-level coordination.
        ii. The Strategic Alignment Team's role in improving coordination across agencies and building a global view of the MDHHS enterprise.
        iii. Ms. Allen also explained that the Strategic Alignment Team defines the strategic priorities for MDHHS and identifies opportunity for collaboration across agencies on large initiatives or information technology projects.
    e. Ms. Allen explained the role of BIC in reviewing new "work requests" for developing information technology systems.
        i. Ms. Allen noted that the BIC reviews every new request and determines whether resources exist for implementing new systems and whether MDHHS has existing systems that could be leveraged to meet the new business need.
        ii. Ms. Allen emphasized that this systematic review process helps reduce duplication and encourages the "build once, use multiple times" approach.
    f. Ms. Allen described the Program Management Offices (PMO) within BIC.
        i. Ms. Allen noted each PMO is an individual team that coordinates the implementation of a specific portfolio of projects that are similar in nature.
        ii. Ms. Allen also described the roles of different individuals within each PMO such as the Technical Delivery Owner, Business Delivery Liaison, Business Owner, and Project Management Expert.
        iii. Ms. Allen explained that there are several different PMOs that cover the various aspects of the Department's operations.
        iv. Ms. Allen also walked through the process of defining new work requests, scoping those work requests, and prioritizing work.
2. Commissioner Nick Smith inquired about the process for prioritizing work requests.
    a. Ms. Allen explained that prioritization of projects occurs within the PMO and is based on discussions with the respective business areas about what projects needs to get done when.

b. Commissioner Karen Parker explained further that prioritization issues that cannot be resolved at the PMO level are elevated to the Strategic Alignment Team.
c. Commissioner Hegeman-Dingle asked whether the Strategic Alignment Team has been forced to resolve a prioritization issue yet, and Commissioner Karen Parker confirmed that the resolution process had not been used yet.

3. Commissioner Schonfeld inquired about whether any opportunities for improvement had been identified.
    a. Commissioner Schonfeld expressed particular interest in identifying opportunities to improve access to services or expedite different processes for consumers.
    b. Commissioner Parker replied that the Department is still working through the process of defining these opportunities.
4. Commissioner Rinvelt inquired about the number of staff and teams within BIC.
    a. Ms. Allen noted that BIC has 275 staff as well as an assortment of contractors.
    b. Ms. Allen also mentioned that BIC currently has 9 PMOs.
5. Commissioner Dr. Mark Notman asked about how MiHIN fits into this model and how different issues related to the state's partnership with MiHIN are handled.
    a. Ms. Vanderstelt emphasized the importance of the question and noted that the Department is still figuring out how MiHIN fits into this model.
    b. Ms. Allen noted that BIC was officially launched in October 2015 and is still in a transitional phase of defining the process for coordinating MiHIN-related projects.
    c. Ms. Allen also indicated that MiHIN initiatives could fall across multiple PMOs but that the larger BIC structure will enable more effective coordination on MiHIN-related projects across the MDHHS enterprise.
6. Commissioner Schonfeld inquired about how BIC coordinates the various funding sources for MDHHS information technology projects such as State Innovation Model funding, General Fund, and Medicaid 90-10 funding. Commissioner Parker noted that BIC does have a Funding Sources team to evaluate different funding streams for projects and identify the best strategy for leveraging different funding sources.
7. Ms. Vanderstelt noted the importance of the environmental scan in identifying all of the different programs and systems within MDHHS and being the impetus for the development of BIC and the Strategic Alignment Team.

E. Introduction to the MDHHS Strategic Alignment Team

1. Co-Chair Rinvelt invited Mr. Phillip Bergquist of MDHHS to provide an overview of the MDHHS Strategic Alignment Team. The PowerPoint slides for this presentation will be made available on the website after the meeting.
    a. Mr. Bergquist explained that the Strategic Alignment Team was established in response to the merger of the developments and resulting need for greater alignment across programs.
        i. Mr. Bergquist stated that the Strategic Alignment Team acts as a single governing body that develops and supports the implementation of the short-term and long-term vision and strategy.
        ii. Mr. Bergquist also indicated the Strategic Alignment Team is the vision and strategy complement to the operational, implementation, and project management resources within BIC.
    b. Mr. Bergquist explained that the Strategic Alignment Team is composed of the MDHHS Director, Chief Deputy Director, and Senior Deputy Directors.

        i. Mr. Bergquist also highlight the role of “Supporting Leaders” who act as extensions of Strategic Alignment Team members.
        ii. Mr. Bergquist noted that Supporting Leaders analyze various options and provide context to the Strategic Alignment Team members in order to support strategic decision-making.
    c. Mr. Bergquist summarized the functions of the Strategic Alignment Team.
2. Service Integration
3. How do we bring together and unite around a common vision for all programs, services, benefits, etc.?
4. 340 programs within MDHHS
5. Some of these provide a tangible service to an end-user Michigan resident
6. Some serve other community partners
7. Some are environmentally/policy focused
8. One place to bring all skill sets and capabilities together
9. Executive Steering
10. Accountability – monitoring effectiveness, eyes onto scorecards/dashboards/etc.
11. Internal Coordination
12. Finding opportunities for synergies
13. Operational coordination
14. Operational strategy
15. What are we doing across all different organizations
16. Sharing across project teams/technology systems/etc.
17. Organizational Change Management
18. Leadership perspective
19. How do we make sure we’re consistent in engaging staff and partners across the department and proactively lead change?
20. Purposes in Practice
21. Provide a view into the projects, initiatives, work focus of Administration they represent – each representative brings a report on what their area is doing
22. Are we on point?
23. This is some cool work!
24. Limited set of review of work requests when needed
25. Process designed around this
26. Scorecard for Director and Chief Deputy Director
27. Look at how programs services stack up
28. Analysis
29. Where are we investing a lot?
30. Where are we underinvesting?
31. Work as partner in strategic/visioning planning processes
32. Efforts that gain partner and staff input
33. Rinvelt: Measurement and metrics: examples?
34. PB: Publicly available on Open Michigan website
35. Health and wellness dashboard
36. Each strategic priority looks at operational performance metrics within the administrations
37. Is a program reaching its audience? (reaching n veterans?)
38. Population Health metrics
39. Fiscal Year 17 update – make sure that measures are actually capturing strategic success
40. Notman: When you prioritize, do you control budgets, impact finances?

41. PB: The budget process has a lot of input from a strategy alignment. There will be input on the front end. Within a particular line item, we get input from BIC on how this works. SAT gives guidance. Identifying needs for supplemental funding – we may need to work with external funding partners (ISD for example). How do we use existing resources most effectively? Where do we just not have enough resources?
42. Integrated Service Delivery
43. Combination of strategies that get us to a vision
44. Where are we today? Where do we want to be in the next few years?
45. Today: Program focus
46. Tomorrow: Person focus
47. More proactive
48. More holistic look at a person's needs
49. Strategy behind the Scenes (first 5: what do we want to do? Last 5: how do we make the department look like this?)
50. Strategic Alignment
51. Holistic Assessment
52. Common Connector and Plan
53. Robust Self-Service
54. Streamlined Renewal
55. Partner Integration
56. Statewide Resource Index
57. Universal Case Management
58. Process Improvement
59. Consent Management
60. ISD Components
61. ISD Portal – customer-facing
62. Person-Centric Services Modules – IT-centric
63. Universal Caseload Management – Staff doing work
64. Contact Center Development – Customer relationship management
65. Technology Infrastructure Modernization – within MDHHS, what other partners bring technology-wise to the table
66. Hegeman-Dingle: How far away are you from realizing this vision?
67. PB: General answer – about 2 years: A LOT of activity in the next fiscal year/role changing/change management, then a phased rollout process – targeting rollout for piloting in a single area for some ideas, some rollouts will be over broader chunks of the state. Phased piece – how many needs to fulfill? What's underlying IT work that needs to be done?
68. MV: Lots of work of HITC – this is work that can be leveraged on efforts already in place to go statewide. Picks up on work that's been done, let's make that actual!
69. Notman: How do technology folks interface with this related to best approaches/standards/etc.?
70. PB: Within SAT, there's a constant connection with the BIC and our tech architects and business experts.
71. Build vs. buy
72. No longer in a place to start a project then bring IT
73. Or IT starts a project…
74. Business Integration Manager, strategic architect for department
75. Really high level budget leaders are in SAT also.
76. MV is a supporting leader group member.

77. PB: Still growing and developing, but early returns give cause for excitement in work products/recommendations.
78. KP: Integration team primarily will have IT background and will have been with program for several years. ISD will lead to bringing DTMB on board more.
79. Business should be driving, not IT, business should take the lead: BIC!

F. Overview of the Office of Civil Rights HIPAA Guidance

1. Co-Chair Rinvelt invited Mr. David Livesay of MiHIN and Mr. Wagenknecht to provide an introduction on the Medication Reconciliation White Paper and related use cases. The PowerPoint slides for this presentation will be available on the website after the meeting.
2. Direct Secure eMail and Patient Requests for Medical Information
3. MiHIN trying to make people aware of this issue
4. Direct Secure Messaging Overview
5. Direct Secure e-mail
6. Security wrapper to make the e-mail HIPAA-worthy
7. Supported by ONC
8. Baked into HIT certification/meaningful use
9. IN the last couple of years, adoption has picked up a lot. (hockey stick)
10. This is a cheap tool that's familiar. You have less likelihood of spam.
11. Trust fabric set up around it; direct account tied to a specific entity.
12. Can help for getting rid of the fax machine.
13. You can attach a DICOM image or an HL7 message (human and computer readable) to the message.
14. Recent ruling from Office of Civil Rights (OCR)
15. January 2016 ruling around consumers getting access to own information
16. You as a consumer have a right to your own health information.
17. If there's information in electronic form in an EHR (especially one certified), the patient can come and request that information in an electronic format.
18. Very broad with opportunity for consumer to ask for it as direct secure message, some may want it in other ways, etc.
19. If it's in a certified EHR.
20. National Association for Trusted Exchange (focused on consumer-facing activities, like Blue Button, formalized trust bundles for consumers to get at information)
21. Upset: Information Blocking.
22. Not much work to set up communication with patients via Direct
23. But there is work.
24. If you're a provider using an EHR, OCR expects
25. Provider using CEHRT
26. To send to Direct Address supplied by a consumer
27. If the consumer has requested her information be sent this way
28. Pursuant to her HIPAA right of Access
29. IF YOU DON'T…
30. Information blocking attainder could come also.
31. Current Direct Participation
32. Participation growing quickly. Over 1 million physician Direct Addresses.
33. Microsoft Healthvault and other personal health records give "free" direct addresses.
34. Direct HISP vendors planning consumer direct accounts at $20/year.

35. Rinvelt: NATE doing a national campaign to raise awareness? Tim: We should start paying attention to this and connect the dots for folks.
36. Concern: Information Blocking accusation.
37. Hegeman-Dingle: OCR has created three videos about the right to your own information.
38. Tim: Consumers are learning; doctors don't even know about consumers being told.
39. RHD: Technical issues likely
40. Tim: risk of complaints and action by OCR for folks who don't know about this.
41. Tim: Opportunity: Statewide Consumer Directory – automating the capture of preferred electronic service information delivery. Trying to identify a path of least resistance for all providers to make this information provision easier.
42. Notman: Precedent out there that patients have right to this information. Do docs feel responsibility to get the word out?
43. Tim: Shared responsibility with docs. At this point, MiHIN has been advocating for Direct for a while. Direct can be used by care coordinators and health plans too. Least common denominator for killing the fax machine but also interact.
44. Shared responsibility with HITC and HIT community as well as doctors to share this information.
45. MV: MU guidance?
46. CEHRT has Direct as a requirement.
47. Certain transitions of care measures already in MU.
48. Here's how to get it to mobile, how to get it to my e-mail.
49. Notman: Consumer-driven healthcare: this makes it real!
50. Schonfeld: Not sure that this has been measured. We can ask hospitals about this. Note to ask!
51. PS: Hospital systems want to kill the fax machine for work with other physicians.
52. TP: Direct is an opportunity to kill the fax for communication with patients and health plans too.
53. Maki: One of the biggest issues we have is who's issuing Direct Addresses; even when part of direct trust, some organizations are not recognizing the certificates.
54. TP: If you're in the bundle, it often works, but not always. Bruce: Mostly it doesn't work; TP: Probably because they're not in the most recent version…that's not in the bundle. There are a handful of things people buy that are NOT compliant with Direct secure messaging. As a result, they're isolated and proprietary.
55. TP: Portals aren't evil; they're just an imperfect solution. Most organizations have incentives to set up a patient portal and drive patients there.
56. Hegeman-Dingle: Is there a way to use the portal to do this? There are only certain types of information that can be downloaded from the portal, so that's not a sufficient solution.
57. Notman: Information is spotty too. Portals, what's there, etc.
58. Statewide consumer directory can help for pointing to where messages should go statewide.

G. HIT Commission Next Steps

1. Ms. Vanderstelt noted that the next HIT Commission meeting will be held in June.
2. Meeting Schedule for Rest of 2016
3. Phil Kurdunowicz to send survey to HIT Commissioners about availability
4. Meeting Topics for Rest of 2016
5. Rinvelt: Lots of opportunities for discussion, but can't do them all.
6. MV: Let us know perhaps through survey.
7. Areas of focus

8. Stakeholder engagement
9. Governance, Policy, and Innovation
10. Privacy and Security
11. Care Coordination
12. Person-centered Planning
13. Population Health and Data Analytics
14. SIM another touchpoint (MV)
15. Nick Smith suggested using the survey. Commissioners generally agreed on using that to discuss.

H. Public Comment

1. Chair Rinvelt invited the attendees to introduce themselves and offer public comment.
2. Meeting attendees introduced themselves but did not offer any comments.
3. Scott Larsen, Healthcare Cybersecurity Council
4. Provided report to Governor's Cybersecurity Council
5. Program called True North to identify how well they're performing against initial vision. David Behen was pleased at progress to date.
6. Healthcare specific cybersecurity solutions
7. Sharing cybersecurity information between member organizations
8. Several currently active subgroups
9. Third Party Risk, Medical Device Cybersecurity, Training and Awareness, Incident Management Response – Threat Intelligence; piloting a real-time sharing program between hospitals
10. Deloitte conducting cybersimulation workshop
11. Awareness and examples
12. What is your own incident response?
13. Hoping to provide quarterly updates, which hasn't been done since leadership change in January
14. Cynthia Green-Edwards: Also sits on that council and a lot of progress has been made in idea sharing.

I. **Adjourn**

1. Co-Chair Rinvelt asked if there was a motion to adjourn the meeting.
2. Commissioner Dr. Notman made a motion to adjourn the meeting, and Commissioner Hegeman-Dingle seconded the motion.
3. Chair Rinvelt asked if there was any objection to adjourning the meeting. Seeing none, she noted that the meeting was adjourned at 2:45 pm.